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FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Competition
Bureau of Economics

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Simone Salloum
Assistant General Counsel
Texas State Board of Dental Examiners
333 Guadalupe, Suite 3-800
Austin, Texas 78732
rulecomments@tsbde.texas.gov

Dear Ms. Salloum:

The staffs of the Federal Trade Commission's ("FTC" or "Commission") Office of Policy Planning, Bureau of Competition, and Bureau of Economics[1] appreciate the opportunity to respond to the invitation for public comments on two rules proposed by the Texas State Board of Dental Examiners ("Board"): 22 TEX. ADMIN. CODE § 108.70, which would replace the current version of that rule; and 22 TEX. ADMIN. CODE § 108.74, a new rule.[2]

Proposed 22 TEX. ADMIN. CODE § 108.70 imposes new restrictions on the ability of Texas dentists to enter into contracts with "unlicensed persons" for the provision of nonclinical services, such as administrative support and business functions. Proposed 22 TEX. ADMIN. CODE § 108.74 would make dentists who own, maintain, or operate a dental practice that employs a dentist "responsible for all administrative and operational" functions. Although the proposed rules do not expressly refer to Dental Service Organizations ("DSOs"),[3] the rules seem likely to discourage dentists from affiliating with DSOs by mandating that dentists assume responsibility for the types of functions that DSOs typically provide, and by expanding the Board's authority to take disciplinary action against dentists who enter into such prohibited agreements.

FTC staff are concerned that the proposed rules, if they are adopted and if they discourage dentists from affiliating with DSOs, may deny consumers of dental services the benefits of competition spurred by the efficiencies that DSOs can offer. The central theme of this letter is a relatively narrow one; it focuses on the *nonclinical* functions of a dental practice that are unlikely to affect the quality of professional dental care. The rules would restrict the choices dentists have when deciding upon the most efficient way to organize the nonclinical aspects of their practices, and deny them potentially significant cost savings and the ability to focus their own efforts on provision of dental care, rather

than on the business management aspects of running a dental practice. The use of DSOs for these nonclinical purposes may lead to lower prices and increased access to care.

In light of the likely harm to competition and consumers from the proposed rules, FTC staff urge the Board to consider whether reliable evidence indicates that (i) the rules will serve any important public purpose, such as addressing substantiated health and safety concerns or concerns about fraud; (ii) if so, whether the proposed restrictions may be greater than necessary to address such concerns; and (iii) whether less restrictive alternatives might be available.

I. FTC Interest and Experience

The FTC is charged under the FTC Act with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[4] Competition is at the core of America's economy,[5] and vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality products and services, and increased innovation.

FTC staff have particular experience with issues related to dental competition,[6] including dentists' ability to contract with DSOs for the provision of nonclinical, administrative functions.[7] More generally, FTC staff have investigated and reported on the competitive effects of restrictions on the business practices of state-licensed professionals, including dentists, optometrists, physicians, pharmacists, and veterinarians.[8] In addition, staff have submitted comments about the competitive effects of restrictions on the business practices of state-licensed professionals to state legislatures, administrative agencies, and others.[9] We have consistently maintained that the choice of business model is an important dimension of the competitive process that should not be restricted by regulation or private agreement absent reliable evidence that regulation is reasonably necessary to achieve an important public purpose.

In addition to this relevant competition advocacy work, the Commission has used its enforcement authority to challenge professional association rules prohibiting professionals from entering into business relationships with non-professionals. For example, the Commission found that the American Medical Association's (AMA) ethical code provisions, which prohibited physicians from working on a salaried basis for hospitals or other lay institutions and from entering into partnerships or similar business relationships with non-physicians, unreasonably restrained competition and violated federal antitrust laws.[10] The Commission also found there to be no procompetitive justifications for these restrictions and concluded that these prohibitions kept physicians from adopting potentially efficient business formats and precluded competition from organizations not directly and completely under the control of physicians.[11]

II. The DSO Business Model

DSOs are management companies that contract with dentists to provide a variety of nonclinical business services that would otherwise be handled within a practice, or by multiple contractors providing individual services. The services offered are varied, and

may include acquisition or sale of capital equipment and dental supplies; accounting, bookkeeping, payroll, and financial services; billing and collection services; advertising and marketing services; legal services; and management of external laboratory services. Contracting for these kinds of business functions can allow dentists to focus on practicing dentistry, rather than operating a small business, for which they may have limited training.[12]

DSOs are often organized as corporations owned by non-dentists. They usually have offices at more than one location, and may be referred to as "group practices" or "chains." The contractual relationship between dentists and non-dentists varies according to state law. Most states, including Texas, do not permit non-dentists, including corporations, to own dental practices or employ dentists and allied dental professionals.[13]

The common attribute of DSOs is that they are "networks of small practices aligned with a central management organization that provides a veritable array of business services for a professional group that provides clinical care."[14] Such an arrangement may provide "efficient centralized management and a number of small practices located 'where the patients are.'"[15] Other efficiencies claimed by DSOs include the ability to purchase equipment and supplies at reduced prices and the ability to build or lease office space economically.[16] The percentage of dentists affiliated with such multi-site companies is small but growing, especially among recent dental school graduates who may not have the resources necessary to establish an individual practice.[17]

Some DSO-affiliated dentists have been especially active in providing care to underserved populations, including those that rely on Medicaid.[18] Recent surveys showed that nationally, while only 6.4 percent of dentists were affiliated with a DSO,[19] DSO-affiliated dentists provided 21 percent of the care received by children in the Medicaid program.[20] In part, the relatively high percentage of care provided to Medicaid beneficiaries by DSO-affiliated dentists may reflect low participation in the program by many non-DSO-affiliated dentists, many of whom do not accept Medicaid because of its low reimbursement rates.[21] One commentator has suggested that efficiencies achieved by the DSOs' business model enable DSO-affiliated dentists to accept Medicaid rates and still be financially viable: "In general the business model for these Medicaid [DSOs] succeeds financially because they are able to reduce operating costs by locating in economically depressed areas (where real estate and employee costs are low), purchasing in bulk (to avail themselves of quantity discounts), and providing flexible scheduling that recognizes the impediments that many low income families face with transportation and work arrangements."[22]

Some DSO critics have maintained that the DSO business model and involvement of non-dentists creates incentives for low quality care, over-treatment of Medicaid patients, and Medicaid fraud.[23] We understand that Medicaid fraud has been of particular concern in Texas with regard to DSOs.[24] Recent audits by the U.S. Department of Health and Human Service's Office of Inspector General (OIG), however, did not identify the DSO model or any particular business model as a culprit. Rather, the audits found that a broader cause of the high expenditures in Texas's Medicaid orthodontics program was a

need for improved measures by the state to "ensure that the prior-authorization process was used to determine the medical necessity of orthodontic services under State Medicaid guidelines."[25] As recommended by the OIG, Texas has taken steps to ensure the integrity of its Medicaid dental program through the proper use of the Medicaid prior-authorization process and review of claims.[26]

III. Key Changes That Would Arise from the Proposed Rules

If adopted, the proposed changes to the Board's rules likely would make it very difficult for dentists to contract with DSOs, and even with companies that provide individual management and administrative support services to dental practices. The contrast between the current rules, which focus on activities related to professional judgment, and the proposed rules' restrictions on business, management, and administrative support services is especially clear in proposed § 108.70(d). Unlike the current rules, § 108.70(d) would prohibit dentists from entering into agreements that give unlicensed persons, including corporations, control of various business functions.

The list of covered business functions is long, and agreements covering any *one* of the functions are prohibited. For example, proposed § 108.70(d)(4) would prohibit dentists from entering into agreements giving unlicensed persons sole control of functions often provided by DSOs, such as banking; acquisition or sale of equipment and supplies; accounting, bookkeeping, payroll, investment, or financial services; billing and collection services; advertising and marketing services; or business and personnel practices.[27]

The list of functions covered by proposed § 108.70(d)(4) is particularly striking because agreements for many of these functions are presumed *not* to violate the Texas Dental Practice Act as it stands now. Currently, § 108.70(c) provides safe harbors for agreements covering many business functions, such as the acquisition or sale of equipment and supplies; accounting, bookkeeping, investment, or similar financial services; financing or ownership of non-dentist business equipment; billing and collection services; and advertising and marketing services.[28] The proposed new version of § 108.70, however, does not contain § 108.70(c) or any other safe-harbor provisions.

Proposed § 108.74(c) also appears to expand the scope of prohibitions on non-dentists' provision of business services, stating that "[n]on-owners may advise the owner on administrative and operational matters" but that a dentist owner is legally "responsible for all administrative and operational functions" of a practice, including nonclinical functions often provided by DSOs, such as: providing a practice with the necessary equipment and resources; billing and invoicing patients; and submitting claims to third party payers for reimbursement.[29] Violations of this provision or proposed § 108.70(d) could lead to disciplinary action pursuant to Texas's Dental Practice Act.[30] It is not clear what administrative or operational functions offered by DSOs, if any, would qualify as advisory. As a result of the ambiguity in this proposed regulation, and the clear prohibitions of § 108.70(d), contracting with a DSO likely would become riskier and less

common, which would deprive the market of the competitive benefits those foregone DSO arrangements otherwise would have had.

IV. Likely Competitive Effects

Competition spurs both current providers and potential entrants to develop more efficient and innovative ways to deliver their services, without compromising quality. For these reasons, in health care markets as in other markets, competition should be restricted only when necessary to protect against a credible risk of harm, such as health and safety risks to consumers, or fiscal risks to the government. Any warranted restrictions should be narrowly crafted to minimize their anticompetitive impact.[31] DSOs can increase efficiency and support entry of new dental practices. Dentists generally have little training in administration, which means that carrying out administrative tasks can be time consuming. Relieving dentists of the need to perform administrative tasks could increase the amount of dentistry services dentists could provide, and lower the costs of providing dental services. In addition, DSOs may support entry into Texas, or prevent exit, by dentists who prefer to affiliate with a DSO.[32] This new entry may lead to lower prices, expanded services, and improved access to dental services. Because the proposed rules may well deter licensed dentists from contracting with DSOs, the proposed rules appear likely to impede competition and deprive consumers of these potential benefits.

Although there has been justifiable concern about fraud in Texas's Medicaid dental programs, broad restraints on contractual arrangements with non-dentist providers of business services such as DSOs are unlikely to address such concerns.[33] Incentives for over treatment "exist across all dental provider types as virtually all dental care in the US is paid on a fee-for-service quantity-of-care basis."[34] The OIG's recommendations to Texas's Health and Human Services Commission noted above are specifically designed to address the suspected problems and appropriately cover DSO- as well as non-DSO-affiliated dentists.[35] Importantly, this type of solution does not risk losing the efficiency and competition benefits that DSOs may provide.

A. Dental Care: Price and Access

Proposed 22 TEX. ADMIN. CODE §§ 108.70 and 108.74 likely would create a very restrictive regulatory environment for DSOs and other companies that provide administrative services to Texas dental practices. Although Texas's Dental Practice Act prohibits the Board from adopting rules that would prevent a dentist from contracting with a management service organization,[36] dentists may be reluctant to enter into agreements with DSOs or other companies that provide such services. In addition, some dentists may seek to terminate existing contracts because the safe harbors for such contracts would be eliminated and the new regulations could subject them to disciplinary action for entering into such agreements.

As a result, the proposed regulatory restrictions likely would lead to reduced competition in the markets for dental management services and dental care. The unfavorable business climate may discourage DSOs from entering Texas, and facilitate

the exit of those currently operating in Texas, resulting in less competition in the markets for dental management services. The restrictions on affiliating with a DSO might also reduce competition among dentists in Texas to the extent that dentists who value DSO services choose not to practice in the state. The unfavorable business climate for DSOs might have the greatest effect on newly licensed dentists who lack the resources to start a practice, and on dentists who prefer to concentrate on the professional practice of dentistry rather than on business functions.[37] In addition, the development of potentially more efficient DSO-affiliated practices that may be able to offer lower prices would be inhibited, further reducing competition among dentists.[38] Ultimately, the restrictions on dentists and DSOs would impact Texas consumers, who will be deprived of the potential for lower prices and increased access to dental services.

Texas's underserved communities would be particularly vulnerable to these potential anticompetitive effects. Nearly five million Texans, 19.3 percent of the population, live in a Dental Health Professional Shortage Area.[39] DSO-affiliated dentists have been particularly active in serving underserved populations and could help address some of these needs.[40] Constraining the operation of DSOs likely would restrict further the supply of dental services in these communities, exacerbating current shortages. Reductions in access to dental services, including preventive dental care, could lead to increases in future dental costs and other health care costs.[41] Such costs could burden not only individual patients, but also the state's Medicaid program.

B. Regulations That Restrict Competition Should be Narrowly Tailored

Some states have enacted laws or regulations that prevent licensed health care professionals from entering into employment or other commercial relationships with non-licensed entities, on the theory that such restrictions are necessary to preserve the provider's independent judgment and adherence to professional standards. The anticompetitive effects of such restrictive provisions, however, may reduce efficiency and quality rather than enhance quality. Most studies find quality to be *unaffected* by regulation of business practices and in some cases quality actually decreases in response to the restrictions.[42]

Since the proposed changes may be intended to address concerns about the independent judgment of dental professionals,[43] we note that Texas already has laws and regulations to address concerns that a DSO-affiliated practice might be compromised due to the financial interests of owners who are not licensed professionals. Texas, like many other states, has laws prohibiting corporations and other non-licensed entities from owning a dental practice or employing a dentist.[44] In addition, Texas's Dental Practice Act already prohibits dentists from entering into agreements that have the effect of controlling or influencing their professional judgment.[45]

Proposed regulations to limit commercial relationships between dentists and non-licensed entities should be carefully examined to determine if they are based on credible and well-founded safety, quality, or other legitimate justifications. To the extent possible, restrictions should be narrowly tailored to minimize their potential anticompetitive

effects, and to avoid unduly discouraging innovative and efficient models of practice that could compete against traditional providers without compromising safety or quality. Otherwise, such restrictions can be expected to inhibit competition, increase prices, and decrease access to dental services. Moreover, those anticompetitive effects could impose the greatest impact on underserved populations that can least afford it, and state programs that cover such costs.

V. Conclusion

Restrictions on the ability of dentists to contract out business functions provided by DSOs may reduce competition by preventing the emergence and expansion of efficient forms of professional practice that could increase the supply of dental services. The proposed rules appear unnecessary to address any concerns about the independent judgment of dental professionals—DSO-affiliated dentists retain full control over the clinical aspects of caring for their patients and Texas already has laws and regulations that prohibit unlicensed persons from influencing a dentist's professional judgment. In addition, although there have been concerns about unauthorized treatment and the quality of care provided to Medicaid dental patients, Texas's Health and Human Services Commission is taking action to address these problems by ensuring proper oversight of the prior-authorization process and adherence to Medicaid policy and procedures. By contrast, sweeping restrictions on agreements with non-dentist providers of business support services will not address the fraud and abuse. For these reasons, we urge the Board to consider the potential anticompetitive effects of the proposed rules, including higher prices and reduced access to dental services, especially for underserved populations, and to reject both proposed § 108.70 and § 108.74.

We appreciate your consideration of these issues.

Respectfully submitted,

Andrew I. Gavil, Director
Office of Policy Planning

Michael G. Vita, Acting Director
Bureau of Economics

Deborah Feinstein, Director
Bureau of Competition

[1] This staff letter expresses the views of the Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics. The letter does not necessarily represent the views of the Federal Trade Commission or of any individual Commissioner. The Commission, however, has voted to authorize staff to submit these comments.

[2] *See* 39 Tex. Reg. 6973, 6975 (Sept. 5, 2014). The open comment period extends 30 days from the date of publication in the Texas Register. *Id.*

[3] A DSO is defined under Texas law as "an entity that . . . is owned wholly or partly by a person who is or is not a dentist; and . . . under a dental service agreement, provides or offers to provide services to a dentist or employs or otherwise contracts with a dentist in the dentist's capacity as a dentist." TEX. OCC. CODE ANN. § 254.019(a)(2).

[4] Federal Trade Commission Act, 15 U.S.C. § 45.

[5] Standard Oil Co. v. Fed. Tr. Comm'n, 340 U.S. 231, 248 (1951) ("The heart of our national economic policy long has been faith in the value of competition.").

[6] *See, e.g.*, Comment from FTC Staff to the Comm'n on Dental Accreditation (Dec. 2, 2013), http://www.ftc.gov/policy/policy-actions/advocacy-filings/2013/12/ftc-staff-comment-commission-dental-accreditation (concerning accreditation standards for dental therapists); N.C. State Bd. of Dental Exam'rs v. FTC, 717 F.3d 359 (4th Cir. 2013), *cert. granted*, 134 S.Ct. 1491 (2014) (upholding an FTC ruling that the North Carolina State Board of Dental Examiners illegally thwarted lower-priced competition by engaging in anticompetitive conduct to prevent non-dentists from providing teeth whitening services to consumers in the state); In re S.C. State Bd. of Dentistry, 138 F.T.C. 229, 233-40 (2004), *available at* http://www.ftc.gov/os/adjpro/d9311/040728commissionopinion.pdf (FTC opinion on an interlocutory appeal in a case challenging the South Carolina Dental Board's adoption of a requirement, which the state legislature had eliminated, that a dentist examine all school children receiving care from a dental hygienist); In re S.C. State Bd. of Dentistry, FTC Dkt. No. 9311, Decision and Order (2007), *available at* http://www.ftc.gov/os/adjpro/d9311/070911decision.pdf (consent agreement settling charges concerning the requirement for examination by a dentist for certain preventative dental services provided by a dental hygienist in a school); Comment from FTC Staff to the Me. Bd. of Dental Exam'rs (Nov. 16, 2011), http://ftc.gov/os/2011/11/111125mainedental.pdf (concerning proposed rules to allow dental hygienists to take X-rays in underserved areas); Comment from FTC Staff to the Ga. Bd. of Dentistry (Dec. 30, 2010), http://ftc.gov/os/2010/12/101230gaboarddentistryletter.pdf (concerning proposed rule governing supervision of dental hygienists); Comment from FTC Staff to the La. State Bd. of Dentistry (Dec. 18, 2009), http://www ftc.gov/os/2009/12/091224commentladentistry.pdf (concerning proposed rules on the practice of portable and mobile dentistry); Comment from FTC Staff to the La. House of Representatives (May 1, 2009), http://www.ftc.gov/os/2009/05/V090009louisianadentistry.pdf; Comment from FTC Staff to the La. House of Representatives (May 22, 2009), http://www.ftc.gov/os/2009/05/V090009louisianahb687amendment.pdf (concerning legislation on the practice of in-school dentistry); *see generally Advocacy Filings by Subject, Dentistry*, FED. TRADE COMM'N, http://ftc.gov/opp/advocacy_subject.shtm#detg (last visited Sept. 30, 2014).

[7] *See* Comment from FTC Staff to the Hon. Stephen LaRoque, N.C. House of Representatives (May 25, 2012), http://ftc.gov/os/2012/05/1205ncdental.pdf (concerning North Carolina House Bill 698 and the regulation of dental service organizations and the business organization of dental practices in North Carolina).

[8] *See, e.g.*, Okla. State Bd. of Veterinary Med. Exam'rs, 113 F.T.C. 138 (Jan. 31, 1990) (consent order against the Oklahoma State Board of Veterinary Medical Examiners for allegedly restricting veterinarians from being partners with, employed by, or otherwise associated with non-veterinarians or veterinarians licensed in other states); RONALD S. BOND ET AL., FED. TRADE COMM'N, STAFF REPORT ON THE EFFECTS OF RESTRICTIONS ON ADVERTISING AND COMMERCIAL PRACTICE IN THE PROFESSIONS: THE CASE OF OPTOMETRY (1980), http://www.ftc.gov/sites/default/files/documents/reports/effects-restrictions-advertising-and-commercial-practice-professions-case-optometry/198009optometry.pdf; F. KELLY SMITH

ET AL., FED. TRADE COMM'N, STAFF REPORT ON ADVERTISING OF VETERINARY GOODS AND SERVICES (1978), http://www.ftc.gov/reports/staff-report-advertising-veterinary-goods-services.

[9] FTC and staff advocacy may comprise letters or comments addressing specific policy issues, Commission or staff testimony before legislative or regulatory bodies, amicus briefs, or reports. *See, e.g.*, Comment from FTC Staff to the Hon. Patricia Todd, Ala. House of Representatives (April 26, 2012), http://www.ftc.gov/os/2012/04/120426alabamaletter.pdf (commenting favorably on the bill and discussing the harm that can result from restrictions on the business practices of state-licensed professionals); Comment from FTC Staff to the Hon. John T. Bragg, Tenn. House of Representatives (Feb. 2, 1996), http://www.ftc.gov/be/v960005.shtm (commenting favorably on a bill to eliminate restrictions on veterinarians being employed by non-veterinarians); Comment from FTC Staff to the Tex. Sunset Advisory Comm'n (Aug. 14, 1992), http://www.ftc.gov/be/healthcare/docs/AF%2017.pdf (commenting on review of legislation governing various professional boards, including dentists, veterinarians, and physicians, noting "studies have found little relationship between restrictions on professionals' business practices and the quality of care provided"); *Barriers to Entrepreneurship: Examining the Anti-Trust Implications of Occupational Licensing: Hearing Before the H. Comm. on Small Business*, 113th Cong. (2014) (statement of Andrew I. Gavil, Dir., Office of Policy Planning, Federal Trade Commission), *available at* http://smbiz house.gov/UploadedFiles/7-16-2014_Revised_FTC_Testimony.pdf.

[10] Am. Med. Ass'n, 94 F.T.C. 701 (1979), *aff'd* 638 F.2d 443 (2d Cir. 1980), *aff'd mem. by an equally divided court*, 455 U.S. 676 (1982).

[11] Am. Med. Ass'n, 94 F.T.C. at 1012-13, 1015-18.

[12] *See* Albert H. Guay, *The Evolution of Dental Group Practices*, 41 CAL. DENTAL ASS'N J. 899, 900-02 (2013), *available at* http://www.cda.org/Portals/0/journal/journal_122013.pdf. In addition, some DSOs may provide continuing education and training. *See id.* at 902.

[13] *See* JIM MORIARTY & MARTIN J. SIEGEL, SURVEY OF STATE LAWS GOVERNING THE CORPORATE PRACTICE OF DENTISTRY 44 (2012), *available at* http://oversight house.gov/wp-content/uploads/2012/04/4-25-12-Survey-of-State-Laws-Governing-the-Corporate-Practice-of-Dentistry.pdf (listing six states that permit full or partial ownership of dental practices by business corporations). *See also* Guay, *supra* note 12, at 901, 902 (noting that "[t]he issue of the legality of the ownership of a dental practice by anyone other than a licensed dentist complicates the structure and the relationship between the professional and business management aspects of a practice that contracts with a management organization").

[14] Guay, *supra* note 12, at 902.

[15] *Id.*

[16] *Id.* at 903.

[17] Albert H. Guay et al., *Evolving Trends in Size and Structure of Group Dental Practices in the United States*, 76 J. DENTAL EDUC. 1036, 1039, 1041-42 (2012), *available at* http://www.jdentaled.org/content/76/8/1036.full.pdf+html. In 2007, the percentage of dentists affiliated with large multi-site practices was 6.4% nationwide, and 8.7% in Texas. *See id.* at 1039, 1041. *See also* James D. Condrey, *Dental Practice Models in Texas*, 130 TEX. DENTAL J. 996 (2013) (noting that although solo and small practices dominate the marketplace in Texas, "the anticipated growth of large group practices . . . is challenging the traditional model").

[18] The provision of prompt, high quality dental care is important not only to overall health, but also the prevention of major dental disease. *See, e.g.*, INST. OF MED., NAT'L ACADS., ADVANCING ORAL HEALTH IN AMERICA 16-17, ch. 2 (2011), *available at* http://www.nap.edu/catalog.php?record_id=13086&utm_expid=4418042-5 krRTDpXJQISoXLpdo-1Ynw.0&utm_referrer=http%3A%2F%2Fwww.iom.edu%2FReports%2F2011%2FAdvancing-Oral-Health-in-America.aspx (discussing the connection between oral health and overall health and well being). *See also infra* note 41 and accompanying text.

[19] *See* Guay, *supra* note 17.

[20] *See* Burton L. Edelstein, Children's Dental Health Project, *Issue Brief: Dental Visits for Medicaid Children: Analysis and Policy Recommendations* 3 (2012) (data from 2009), *available at* https://www.cdhp.org/resources/173-dental-visits-for-medicaid-children-analysis-policy-recommendations; *see also* Andrea Janik, *My Positive Experience*, 131 TEX. DENTAL J. 142, 143 (2014) (on "We Serve Day" in 2013, one DSO donated services of its affiliated dentists to patients throughout the United States).

[21] *See, e.g.*, U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-11-96, ORAL HEALTH: EFFORTS UNDER WAY TO IMPROVE CHILDREN'S ACCESS TO DENTAL SERVICES, BUT SUSTAINED ATTENTION NEEDED TO ADDRESS ONGOING CONCERNS 11-13 (2010), http://www.gao.gov/assets/320/312818.pdf; U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-09-723, MEDICAID: STATE AND FEDERAL ACTIONS HAVE BEEN TAKEN TO IMPROVE CHILDREN'S ACCESS TO DENTAL SERVICES, BUT GAPS REMAIN (2009), http://www.gao.gov/assets/300/296224.pdf.

[22] Edelstein, *supra* note 20, at 3.

[23] *See, e.g.*, JOINT STAFF OF SENATE COMM. ON FINANCE AND COMM. ON THE JUDICIARY, 113TH CONG., S. PRT. 113-16, REPORT ON THE CORPORATE PRACTICE OF DENTISTRY IN THE MEDICAID PROGRAM 6-7, 17, 32 (Comm. Print 2013), *available at* http://www.finance.senate.gov/library/prints/download/?id=1c7233e0-9d08-4b83-a530-b761c57a900b (recommending that states enforce "laws against the corporate practice of dentistry" to prevent substandard care arising from "dental management services agreements . . . that allow companies to operate dental clinics under the guise of providing administrative and/or financial management support.").

[24] STAFF OF H. COMM. ON OVERSIGHT AND GOVERNMENT REFORM, 112TH CONG., UNCOVERING WASTE, FRAUD, AND ABUSE IN THE MEDICAID PROGRAM 17 (2012), http://oversight.house.gov/wp-content/uploads/2012/04/Uncovering-Waste-Fraud-and-Abuse-in-the-Medicaid-Program-Final-3.pdf ("[M]assive fraud was occurring in Texas's Medicaid dental and orthodontics program . . . ." which "was spending about as much on orthodontic services as the rest of the country's Medicaid programs spent on orthodontic services combined.").

[25] OFFICE OF INSPECTOR GEN., DEP'T HEALTH & HUMAN SERVS., TEXAS DID NOT ENSURE THAT THE PRIOR-AUTHORIZATION PROCESS WAS USED TO DETERMINE THE MEDICAL NECESSITY OF ORTHODONTIC SERVICES i (2014), https://oig hhs.gov/oas/reports/region6/61200039.pdf. The lack of oversight and use of the prior-authorization process was disclosed in an earlier report. *See* STAFF OF H. COMM. ON OVERSIGHT AND GOVERNMENT REFORM, *supra* note 24, at 17 ("Texas failed to effectively oversee and manage its Medicaid orthodontia program, particularly the prior authorization process.").

[26] On May 9, 2014, Texas's Health and Human Services Commission, the state agency responsible for the oversight of its Medicaid dental program, took steps to address OIG's recommendations, including terminating the contractor it had used for reviewing Medicaid claims, transitioning Medicaid recipients to managed care, and hiring a dental director to monitor the dental program. *See* OFFICE OF INSPECTOR GEN., *supra* note 25 at 5, 9.

[27] *See also* 22 TEX. ADMIN. CODE § 108.70(d)(6) (proposed), prohibiting dentists from entering into agreements that give an unlicensed person authority to share or receive "profits . . . from the sale of a dental practice, patient charts, goodwill, or patient lists."

[28] Agreements listed in 22 TEX. ADMIN. CODE § 108.70(c) are presumed not to violate the Texas Dental Practice Act, TEX. OCC. CODE ANN. § 251.003, which defines the activities that constitute the practice of dentistry.

[29] By contrast, the Texas Dental Practice Act only addresses a dentist's responsibility for *professional acts* of others employed by, or in a contractual relationship with the dentist. *See* TEX. OCC. CODE ANN. § 259.004(b).

[30] *See* 22 TEX. ADMIN. CODE § 108.70(e) (proposed), making violators of proposed 22 TEX. ADMIN. CODE § 108.70(d) subject to discipline pursuant to the Texas Dental Practice Act, TEX. OCC. CODE ANN. § 263.002(a)(8). Under § 263.002(a)(8), various levels of disciplinary action may be imposed on a person who "holds a dental license and employs, permits, or has employed or permitted a person not licensed to

practice dentistry to practice dentistry in an office of the dentist that is under the dentist's control or management." In combination, proposed 22 TEX. ADMIN. CODE §§ 108.70, 108.74 might be sufficiently restrictive as to contravene Texas's Dental Practice Act, which provides that "Rules adopted by the board under this subtitle may not preclude a dentist's right to contract with a management service organization." TEX. OCC. CODE ANN. § 254.011(b).

[31] *Cf.* FTC. v. Ind. Fed'n of Dentists, 476 U.S. 447, 459 (1986) ("Absent some countervailing procompetitive virtue," an impediment to "the ordinary give and take of the market place . . . cannot be sustained under the Rule of Reason.") (internal quotations and citations omitted).

[32] *See* Guay, *supra* note 12, at 900-01, 903-04; Guay, *supra* note 17, at 1042.

[33] *See supra* notes 23-26 and accompanying text.

[34] Edelstein, *supra* note 20, at 3. In addition, one commentator has explained that, "[u]nlike some of the other dental delivery sectors, the largest and best managed of the [DSOs] utilize rigorous metrics that seek to identify and address practitioners who over treat." *Id. See also* Janik, *supra* note 20, at 143 (dentist affiliated with a DSO explains that rather than maximizing profit for a distant corporation, she has "control over the treatment plans of [her] patients . . . control over [her] schedule, [her] patient load . . . there is nothing that comes between [her] and providing the best possible dental care to [her] patients . . . ."); OFFICE OF INSPECTOR GEN., DEP'T HEALTH & HUMAN SERVS., QUESTIONABLE BILLING FOR MEDICAID PEDIATRIC DENTAL SERVICES IN NEW YORK 2, 3 (2014), http://oig hhs.gov/oei/reports/oei-02-12-00330.pdf (individual provider "billed Medicaid for 991 procedures on a single day" and was later convicted of grand larceny).

[35] *See* OFFICE OF INSPECTOR GEN., *supra* note 25 at 5, note 26.

[36] *See* TEX. OCC. CODE ANN. § 254.011(b).

[37] *See* Guay, *supra* note 12, at 900-01, 903-04; Guay, *supra* note 17 at 1042.

[38] *See generally* Edelstein, *supra* note 22 and accompanying text.

[39] *See* KAISER COMM'N ON MEDICAID & THE UNINSURED, KAISER FAMILY FOUND., ORAL HEALTH IN THE US 2 (June 2012), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8324.pdf (based on 2010 census data at http://www.census.gov/2010census/data/).

[40] *See supra* notes 19-22 and accompanying text.

[41] *See, e.g.*, INST. OF MED., NAT'L ACADS., *supra* note 18, at 7 ("A focus on prevention may help to reduce the overall need for treatment, reduce costs, and improve the capacity of the system to care for those in need."); *id.* at 46 ("Aside from clinical effectiveness, many studies support the cost-effectiveness of preventive dental care, often due to the avoided expensive treatments associated with severe dental disease").

[42] *See* CAROLYN COX & SUSAN FOSTER, FED. TRADE COMM'N, , THE COSTS AND BENEFITS OF OCCUPATIONAL REGULATION 25 (1990), http://www.ftc.gov/system/files/documents/reports/costs-benefits-occupational-regulation/cox_foster_-_occupational_licensing.pdf (emphasis in original). This report, a review of economic studies of licensing, found licensing frequently increases prices and imposes substantial costs, but generally does not appear to increase the quality of service, especially with respect to restrictive regulation of business practices. The report recommends careful weighing of likely costs against prospective benefits. *See generally id.* at 25-27, 29-36 for a discussion of effects from restrictions on the business practices of licensed professionals.

[43] Telephone discussion with Simone Salloum, Assistant Gen. Counsel, Tex. State Bd. of Dental Exam'rs, (Sept. 23, 2014).

[44] An unlicensed person (or corporation) engages in the illegal practice of dentistry if the person "owns, maintains, or operates an office or place of business in which the person employs or engages under any type of contract another person to practice dentistry." TEX. OCC. CODE ANN. § 251.003(a)(4). *See also* TEX. OCC. CODE ANN. § 256.001 (license is required to practice dentistry); TEX. OCC. CODE ANN. §

251.003(a)(9) (prohibiting unlicensed persons from controlling or influencing dentist's judgment); § 258.001 (dentists may not delegate dental care to unlicensed persons).

[45] An unlicensed person (or corporation) engages in the illegal practice of dentistry if the person "controls, influences, attempts to control or influence, or otherwise interferes with the exercise of a dentist's independent professional judgment regarding the diagnosis or treatment of a dental disease, disorder, or physical condition.") TEX. OCC. CODE ANN. § 251.003(a)(9). *See also* 22 TEX. ADMIN. CODE § 108.70 ("Improper Influence on Professional Judgment").